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ABSTRACT

The current reversal of the rural to urban migration trend among Blacks, American Indians, and Hispanics will create a myriad of coping and adaptation problems for the urban to rural migrant and the rural nonmigrant as well. It is possible to gain a partial understanding of the likely problems by reviewing studies of the ethnic minorities' rural to urban migration and the coping patterns of rural and migrant communities. New migration patterns will undoubtedly affect mental health and substance abuse, two areas closely tied to coping and adaptation strategies. Studies of the incidence of mental illness among rural and migrant minorities have shown no consistent pattern of failure to adjust. Criticism of these studies focuses on their use of hospital statistics to determine incidences of mental illness and their failure to consider migrant characteristics and circumstances under which a move occurred. The type and extent of substance abuse varies among ethnic groups but is increasing for the rural and migrant ethnic minorities as it is for their urban counterparts. Although studies have identified stresses which affect substance abuse, they have not determined the impact of social mobility and environmental change on substance abuse. Among the many research needs is the need to identify the indigenous mechanisms used to control and prevent emotional problems and abuses of narcotics and alcohol. (JH)

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Overview

Preparation of a paper addressing the special needs and problems of rural communities and migrant minorities is a complex and demanding task. The breadth of the subject by itself is extensive. When the areas of alcohol, drug abuse, and mental health are added, the task becomes more complex. Moreover, America's salient ethnic minority groups are complex social systems. No single treatise has effectively identified the broad range of psychosocial characteristics particular to any one group. Some groups, like the American Indian, have received enormous attention by social scientists. Yet, despite the attention given the first American, large knowledge gaps persist. Nonetheless, data does exist that identifies common ethnic minority experiences, particularly the kind generated by racism. In addition, small bits of knowledge are available which point to particular needs and problems which encompass mental health and substance abuse issues.

Many American Indians, Asian Americans, Blacks, and Hispanics argue that each respective group is unique and apart from the other (Trimble, 1977;

Williams, 1976; Yee, 1975; Okura, 1975; and Sue and Chin, 1976). Moreover, many ethnic minority scholars and lay people alike emphasize the range of differences inherent within each group. Sue (1977) amplified this when he stated, "Even the concepts of Native Americans and Asian-Americans encompass many different groups." (p. 617) Participants at a 1977 meeting on Mental Health Needs of Hispanic-American Communities pointed out that, "Hispanics are not a homogeneous group . . . . Each differs in some respects and this variability must be recognized." (p. 1) Among Native Americans, there are well over 200 different tribes, each markedly different from the other. Add to tribal diversity the scatterings of Indians and Alaska Natives in urban and rural communities across the country, each believing that their problems are unique, and one has a sense of the enormity of the complications. Understanding of the unique dimensions of each ethnic-minority group is essential if science and the government are to be responsive and effective in delivering services and programs.

If America's ethnic-minorities have one overwhelming commonality, it's their rootedness in the land and a shared understanding of the rural life style. Indeed, American Indians, Blacks and Hispanics historically share common rural beginnings. The first Asians imported to the United States were placed in rural railroads and mining work camps. Today, about 50 percent of each ethnic-minority group still resides in rural communities with the possible exception of Asian Americans.

Many urban ethnic-minority families have direct ties with kin still living in rural areas. Recent census information shows a reversal of the rural to urban migration trend among Blacks, Hispanics and Indians. Blacks

from the northern cities are beginning to resettle areas in the south, seeking not only an improved economic lifestyle but a rural environment as well. The same finding is occurring among Indians and, on a smaller scale, among Hispanics. The swelling of the rural environments by ethnic minorities can introduce problems unforeseen and different from those experienced in major urban centers.

Internal migration, whether voluntary or unvoluntary, is not a new and different experience for ethnic minorities. Hispanics, to a large extent, make up the greatest percentage of migrant workers in this country. The migrant worker, as such, is accustomed to movement, settlement and resettlement. Constant movement in an effort to sustain economic welfare has created a distinct and unique lifestyle for the migrant worker. Coping and adaptation strategies are tightly woven in a social fabric whose foundation is built on social and environmental change.

Just as the migrant ethnic minority anticipates and expects change, the rural minority prefers the slow-paced sedentary lifestyle. Change in the rural area, whether it be a village on Norton Sound in Alaska, a reservation in South Dakota, a border-town in south Texas, or a small town in Arkansas, comes slowly and, when it does, painfully and reluctantly. Rural folk prefer the status quo and seem to permit the kind of change that will make quality of life just a little better.

Thus, among present-day ethnic minorities, we have a strange set of circumstances. For rural folk, change is not too welcomed. The rural migrant worker expects and seemingly adapts effectively to change. Somewhere in between the two orientations exists the urban ethnic minority who is

returning to the rural lifestyle. Settlement and resettlement in rural areas can and will present a myriad of coping and adaptation difficulties for the urban to rural migrant and permanent residents of the rural town or migrant camp. It's difficult to predict the nature and extent of the difficulties simply because social scientists, for the most part, have concentrated research efforts on understanding the rural to urban phenomena and urban lifestyles in general.

A partial understanding of the nature of the difficulties can be gained from assessing a collection of findings concerning the rural to urban problems of ethnic minorities and coping patterns of rural and migrant communities. To make the task a little easier, emphasis will be placed on mental health and substance abuse, both areas likely to be affected, primarily because they are areas that have a strong relationship with coping and adaptation strategies. In discussing mental health and substance abuse of rural and migrant ethnic minorities, we take the position that: (1) ethnic folk are not well-prepared to tolerate stress when confronted with abrupt social change; (2) salient cultural characteristics and life style experiences affect the degree of responsiveness to social support institutions; and (3) increasing contacts between rural and migrant communities with their urban counterparts are likely to create undesirable circumstances and could induce the need to devise alternate coping strategies to meet economic and psychosocial demands.

Ethnic Minority Perceptions of Mental Health

Social science and biomedical attempts to understand mental health experiences among ethnic minorities are derived from conventional wisdoms rooted in an "occidental psychiatric orientation"; research is molded around the orientation and cast into the timeworn tradition of the scientific method. The combination of these factors has contributed largely to the way mental health experiences are investigated and subsequently interpreted. Thus, contemporary understanding of mental health and substance abuse among rural and migrant minorities is biased; nature and folk interpretations are limited and rarely focused in the literature (cf. Padilla and Ruiz, 1973; Attneave and Kelso, 1977; and Morishima, et al., 1978).

How rural folk perceive mental health experiences and addictive behavior is essential if science and government ever hope to provide solutions to "deviant behavior". The few studies that exist on the subject show that: (1) migrant Hispanics view mental illness as a "misfortune", one that "can be cured" and something for which "one should not be punished" (Derbyshire, 1970). Treatment often is centered around the use of informal community helping networks (Fabrega and Metzger, 1968); (2) mental illness is a state of mind among the more traditional Sioux and is viewed as achieved status within the native world view (Trimble and Medicine, 1976); and (3) hallucinations, delusions and "psychotic-like" behavior reveal an individual's relationship with a greater spiritual force among many rural Blacks. An individual in a "psychotic" state of mind is seen as one who is more in closer contact with religious entities than the average person; that state and the person are revered (Fisher, 1977).

Traditional ethnic minority folklore conceptions are deeply entrenched in history and customs. Madsen (1961) and Trimble and Medicine (1976) strongly urge modern-day practitioners to examine closely the traditional beliefs instead of ridiculing them as superstitious and unfounded in reality.

There is every reason to believe that rural and migrant minorities have little understanding of contemporary psychiatric nosologies and typologies (Karno and Edgerton, 1969). An uneven fit exists between educated investigations and interpretations and rural minority folklore. It seems reasonable to suggest that, as science and government continue to work from a model founded outside the environment in which the problem occurs, accrued knowledge will continue to be inappropriate for dealing with substantive issues embedded in rural folklore. Future efforts should tap into the folklore of this country's rural and migrant minorities and assume a reasonable compromise in the methods and interpretations used. In the meantime, we are faced with knowledge that caters to the educated needs of researchers, practitioners and decision-makers to guide our level of understanding.

Current Mental Health Understandings

Price and Sikes (1974) in their extensive review of rural-urban migration research agree that the mental health data on the adaptation experiences of ethnic minorities is inconclusive. Although most people experience difficulty in adapting and coping with the new environment, urban or rural, the level of stress is typically minimal and short-lived. Among migrant workers specifically, adjustments to new surroundings are dealt with through the use of long-standing, well-refined coping strategies; mental disorders that occur

are typically minor and small in scale. Migrants expect change and prepare themselves psychologically to deal with new circumstances. However, it's usually the unexpected events that create adjustment problems that can be manifested in a number of ways.

Mental health studies of rural-urban migrants typically make use of mental health hospital admissions to determine incidence levels. Lee (1957) compiled data among first admissions to New York hospitals and, after controlling for race, age and sex, found that migrants had higher first admissions rates than nonmigrants for each diagnosed and classified form of psychosis both overall and at specific levels. Using a similar methodological approach, Struening et al. (1970) found that Black and Puerto Rican migrants to New York City had higher rates of hospitalization of mental illness than permanent residents. In addition, Struening et al. (1970) found that, "the number of migrants and the number of relatively permanent residents of the same ethnic group played virtually identical roles in predicting the indicators of social, health and mental health problems" (p. 246). Again, using hospital admissions data, Locke and Duvall (1964) found that nonmigrant Ohio natives had lower first-admission rates than out-of-state migrants.

Mental illness among migrants is often attributed to experience created by social mobility and the degree to which one is accustomed to the phenomenon. If social mobility is a causative factor, it should be looked at more systematically. For example, Kleiner and Parker (1965) found higher incidence of mental illness among Philadelphia Blacks than rural southern Black migrants. In addition, they found that migrants from other areas had lower rates than natives but higher rates than rural southern migrants. In a more comprehensive

study of 2,000 first-admission Black patients to Pennsylvania psychiatric hospitals, Kleiner and Parker (1959) found an overrepresentation of Pennsylvania natives and northern migrants and an underrepresentation of southern migrants. Levels of goal striving behavior, ethnic identity problems, and social mobility were found to be more prevalent among Northern Blacks than southern migrants (Kleiner and Parker, 1970). These psychosocial characteristics are similar to those found among mentally ill groups. Higher rates of mental disorders characteristic of northern Blacks cannot be solely attributed to social mobility, as the northern groups are found to be more mobile than southern migrant groups (Kleiner and Parker, 1970). Social and geographic mobility may be differentially related to psychiatric disturbance, however, sole attribution of higher rates to migrant groups alone is not totally accurate (Micklin and Leon, 1978).

Community Support Systems

Factors such as educational attainment, sex status, and "immediate life experiences" may contribute more to the incidence of mental illness than social mobility. Fried et al. (1971) found the single most important factor in adjustment among Black migrants to Boston was the loss of close ties to people left behind and, more generally, the home environment. Additional factors such as low educational levels, lack of job skills, and for women, social isolation, were found by Fried that contribute to incidences of emotional disturbance of rural to urban migrants. Relatives, as well, can play a significant role in easing adjustment of migrants as substantiated by Omari (1956) in a study of 200 Black migrants in Beloit, Wisconsin. Thus,

presence of relatives and friends combined with length of city residence can be very instrumental in offsetting contribution to mental disorders and psychological stress.

Even though support systems may ease adjustment and coping difficulties, stresses created by migration itself may be the most likely precipitant of mental disorders (Murphy, 1965). Migrant youth, in particular, are very susceptible to peer group influence that have created stress between the Black adolescent and the family (Moses, 1948) and have led to status anxiety, alienation and powerlessness attributed in part to the low status ascribed migrant families (McQueen, 1959). American Indian and Hispanic youth who arrive in the cities with their families often experience identity and value difficulties with nonethnic counterparts (Dinges et al., 1977; Ablon, 1965). To strengthen the need for ethnic identity, relocated American Indians will often exclude non-Indians from formal and informal relations (Ablon, 1964) and restrict youth from joining friendships outside the Indian cultural milieu (Barter and Barter, 1974).

Support provided by the presence of people from the same ethnic minority group also seems to be salient factors in preventing certain forms of mental illness among migrants. Bagley (1968) examined "anomie" as a cause of delinquency and emotional problems among Black migrants. He noted that decreases in diagnosed mental illness is directly associated with increased time in the city and that relatives and friends can often play an important role in curbing one's sense of anomie. Presence of "one's own kind" can provide a cushion for the migrant by assisting in the informal instruction of the normative patterns in the urban neighborhood. Breed (1966), in

studying the effects of migration on suicide, found "duration of residence" as a key factor in adjustment to and accommodation of the urban lifestyle. While there is some evidence to support the significant helpful influences provided by relatives and persons from this ethnic background, more research is needed to identify the nature and characteristics of the informal community helping networks.

Cultural Differences

Settlement experiences of rural to urban migration are rift with conflicts and stresses that stem from the cultural background of the individual and family. The presence of kin and "a colony of one's own kind" is helpful indeed, however, the migrant eventually has to deal with those outside the "cultural circle of awareness". Karno and Edgerton (1969) and Torrey (1969) emphasize that California Hispanics are subject to a variety of stress indicators which are closely related to mental disturbances and self-destructive behavior. Malzburg (1956, 1965) found that migrant Puerto Rican males in 1960 to 1961 have a higher standardized rate of first admissions than non-Puerto Ricans in New York and suggests that rates are due for the most part to cultural and social characteristics. In support of this, Srole et al. (1962, p. 293) maintain that a "complex of exogenous sociocultural forces and pressures converging with endogenous selection processes may create turbulent effects" for migrant Puerto Ricans.

Language is also a major barrier for adjustment and adaptation to the urban environment. Countless numbers of Hispanics, American Indians and Asian Americans have experienced alienation, rejection and despair from an

inability to communicate effectively with potential employees and service agency personnel. Jewel (1952) relates the terrifying experiences of a Navajo male who was erroneously diagnosed as a psychotic because no resident in a Denver mental hospital could comprehend the Navajo language; the unusual syntax of Navajo made it appear that the person was speaking in a garbled language typically indicative of psychotic behavior. Westermeyer (1978) similarly recounts the tragic experiences of Vietnamese relocated to urban areas without any English language training whatsoever; many Vietnamese arrived in communities where no one understood their language.

The impact of cultural differences of migrants and urban natives cannot be underscored enough. Fabrega (1970) confirmed the hypothesis that Mexican Americans exhibit greater disorganization, regression and grossly psychotic behavior among patients because of the general lateness of their hospitalization by their families. It seems that "unacculturated" Mexican American patients have underlying cultural perspectives towards mental illness itself that effect the way the family and the individual respond to the need for treatment; rural Hispanic families take a humanistic approach to helping the individual that departs largely from approaches used in urban areas (Fabrega and Metzger, 1968). Wignal and Koppin (1967) capture the significance of the impact of language and culture on migration and mental health. They maintain that "cultural differences may account for the significant higher admission for Mexican American males . . . here the rate may serve as a measure of the amount of stress produced by acculturation" (p. 146). As a remedy, Anders (1977) argues that one should strive for clear understanding of a migrant's values, linguistic and cultural background.

Perhaps the single most contributing factor to lifestyle adjustment to migration is racism. While relatives and the community can provide support for the migrant, little if anything can prevent the individual from experiencing job discrimination, racist attitudes and behavior of the dominant American culture. As if struggling with the new environment is not enough, the ethnic-minority migrant can be subjected to an impairment of self-image, denial and deception that could lead to increased feelings of inadequacy, withdrawal and self-deprecation (Marmor, 1977). Despite the presence of hard and fast civil rights regulations and affirmative action programs, migrant minorities continue to complain about discrimination and racist practices. Frustrations produced by racist practices tend to increase stress, a major causative factor in psychological disturbances, social deviancy, and mental illness (Kramer et al., 1973).

Forced Migration

Thus far, discussion has emphasized the experiences, accounts and admission rates of rural to urban ethnic minority migrants. Implicit in the discussion is the assumption that the rationale behind relocation and urban settlement was purely voluntary on the migrant's part. However, there are large communities of rural folk who have no choice in the decision to move; in a word, they are forced wittingly or unwittingly to leave their traditional homes to reside in new and unfamiliar environments. Forced movements of ethnic minority groups may consist of isolated family units or may constitute a mass movement of an entire community. During the move, families and significant segments of the group may be broken, in some cases never to reunite (Trimble, 1977).

Some groups are forced to relocate through economic need or decisions imposed by actions of local, state or federal governments. Numerous rural families have been forced to make room for the construction of superhighways, hydroelectric dams, nuclear reactors and fuel-related processing plants (Chapin, 1954). The uprooting of ethnic minority families occurs largely against the will of the residents and has created undue stress due to acculturation and resettlement (Trimble, 1978).

Forced migration is still and will continue to occur in rural segments of the country. Currently, for example, the United States is negotiating with the Navajo and Hopi tribes in Arizona to resolve long disputed land claims. Results from the land entitlement issue will cause the relocation of some 700 Navajo families. The Navajo may adjust, as they have done for centuries, however, there is a strong likelihood that the families will experience emotional duress as a consequence of the experience (Dinges, 1977).

Forced migration, as an issue in the history of America's ethnic minorities, has always had a forceful impact. Migrants, whether they be from Africa, Mexico or Asia or some remote corner of the country, have always experienced difficulties including, but not limited to, the disruption of families and kinship ties, loss of employment and a frequent necessity for drastic shifts in occupational career lines, settlement in a strange community and the likelihood of stress and psychiatric duress. Forced migration issues are of extreme importance to understanding the causes and consequences of future population movements. In contrast to voluntary migration, forced movement is many times more insidious and potentially destructive for the group and individual (cf. Trimble, 1977).

Summary

The incidence of mental illness among rural and migrant minorities paints a confusing picture. Most of the studies emphasize the nature of mental illness among most rural ethnic minorities. Many of the studies reported show higher rates of disturbance among migrants; others show more disturbance for nonmigrants. The rationale behind the onset of disturbance is equally unclear. Social and geographic mobility are offered as explanations, however, migration may not necessarily be the sole cause of emotional problems (Kantor, 1969). Instead, environmental changes resulting from migration may create situations to which the migrant may or may not be able to adjust without mental health consequences. Nonetheless, it is generally argued that stresses connected with the migration and settlement are salient contributing factors in the etiology of emotional difficulties.

If the findings on the etiology of migrant mental illness is mixed, so too are the procedures used to investigate the problem. Sanua (1970) argues that use of hospital statistics to measure relationships between mental illness and migration lead to guess generalizations. Furthermore, he maintains that research could be more fruitful if both migrant characteristics and circumstances under which the move occurred are fully considered.

Thus, adjustments of migrant ethnic minorities is a complicated phenomena and difficult to put into perspective. Add to this the dearth of information on rural mental health in general and the concept becomes more complex. In summary, inappropriate lack of understanding surrounding the rationale for movement and absence of objective criteria leads to the conclusion "that there is no consistent pattern of failure of migrants to adjust" (Price and Sikes, 1974, p. 27).

Substance Abuse: Towards Some Understanding

As a response to emotional problems, people often turn to alcohol and addictive drugs to "take the edge off of reality". Rural and migrant ethnic minorities, like their urban counterparts, are experiencing increased abuses of addictive substances. Beigel, et al. (1974) in an extensive study of alcohol and drug use, found that American Indians rated alcoholism as the most serious health problem; Blacks and Mexican Americans rated it as the second most serious problem, ahead of heart disease and cancer.

Many attribute the high incidence of alcohol and drug abuse to many of the same conditions that create mental illness for rural migrants (cf. Padilla and Ruiz, 1974). Ferracuti (1967) adds to the long list of factors and asserts that drug addiction in particular is more common in countries that undergo rapid social change. Values are challenged and those who follow traditional folk customs are often forced to make a choice. Presence of agringados in south Texas has created value conflicts with long-time residents and has produced a high percentage of problem drinkers (Madsen, 1964). Drug and alcohol use, viewed as an escape mechanism, can continue unchecked so long as practitioners fail to recognize the cultural subtleties inherent in rural folklore.

Abuse of "hard drugs" is not nearly the problem on Indian reservations as it is in urban ghettos (Attneave and Beiser, 1974). Instead of cocaine, opium and heroin, addictions hard to come by in rural areas, Indian youth have turned to sniffing glue, gasoline, paint and spray cans with propellant gases. "In nearly every community," Attneave and Beiser (1974) maintain, "there are adults in their 20's who have serious brain damage and other complications arising from this condition" (p. 88).

Drug abuse among rural American Indians is small in contrast to the alarming rates of alcohol abuse. Abuse rates in excess of 60 percent are not uncommon in many rural Indian communities (cf. Broc, 1974 and Street et al., 1976). Whittaker (1966) attributes the high incidence levels to a: (1) high degree of inter-psychic stresses caused by insecure life on the reservation; disintegration of the tribal culture; and suppression of aggressive tendencies and loathesome feelings towards whites and the government; (2) lack of a suitable substitute for relieving mental stresses; and (3) utilitarian cultural views regarding alcohol consumption that typically receive approval from most community members.

Alcoholism is also a major problem for many American Indians who relocate to the urban environment (Ryan and Ryan, 1978). Ablon (1965) found that alcoholism on the reservation is a factor in deciding to relocate to cities; however, it is the families with drinking problems who are least likely to adjust to urban life. A change in environment and lifestyle probably gives the Indian problem drinker a greater excuse to continue drinking. As such, inability to adjust to an urban lifestyle is a major causal factor of Indian alcoholism in urban settings (Price, 1968).

Adjustment difficulties of urban American Indians stem from a number of factors to include: (1) poor acculturation; (2) social and economic deprivation; (3) lack of marketable job skills; and (4) anomie (Burns et al., 1974). A large part of the psychological stress, anxiety and frustration is vented through heavy alcohol abuse; alcoholism, however, is a symptom, not a cause. "The dearth of mental health data is greater for American Indians, as so little is known about Indians living in cities . . . urban migration

is a very traumatic experience for Indians and . . . urban living is extremely stressful as it heightens the cultural conflict (Chadwick and Stauss, 1975, p. 2).

Rural to urban adjustment problems also are manifest through alcohol abuse among Hispanics and Blacks. Madsen (1964) and Jessor et al. (1968) emphasize the stress-inducing circumstances surrounding Mexican American abuse of alcohol in urban settings. Jessor et al. (1968) isolated salient personality and sociocultural circumstances that give rise to deviant behavior and alcohol abuse among Indians and Hispanics. Deviancy is learned, goal oriented, and adaptive, demonstrating that alcoholism can become an internalized pattern of behavior, however self-destructive, that enables an Indian or Hispanic to cope with stressful conditions.

While drug abuse is not a major problem among migrant Indians, the same cannot be said for Blacks and Mexican Americans. In some communities, heroin, for example, is more accessible to Mexican Americans than Blacks (Redlinger and Michel, 1970). Differential accessibility of drugs can be a major factor in narcotics abuse rates among migrant ethnic minorities. Presence of friends and members of the same ethnic group can enhance the likelihood of access to drugs, particularly if the drug pipeline is controlled by "one's own kind". Redlinger and Michel (1970) point out that Mexican Americans in south Texas do not trust Blacks and, as a result, limited the supplies from Mexico to themselves.

If there is a paucity of information on substance abuse among rural and migrant Blacks, Hispanics and American Indians, then there is even less information available on Asian Americans. What information that is available

suffers from severe limitations and certain erroneous conclusions. Although five articles have been published on the topic (LaBarre, 1946; Barnett, 1955; Wang, 1968; Chu, 1972; and Singer, 1972), only Barnett and Wang offer useful information. The articles concentrate on Chinese drinking behavior and characterize it as: (1) heavy but restrictive in the display of violence and aggressive behavior while intoxicated; (2) a matter of course with little or no ambivalence towards it; (3) a group phenomena where one rarely drinks to excess in solitude; (4) a behavior that is taught to Asian youth; and (5) sanctioned but only at moderate levels.

Lack of available data on the abuse of alcohol and narcotics among Asian Americans largely stems from the need for the community to keep the problems, if they exist, among themselves. Group sanctions prevent or attempt to deter public intoxication simply because many Asian American communities would rather deal with the problems themselves in their own way.

Summary

As one would expect, substance abuse incidences and experiences among rural and migrant ethnic minorities resemble mental health findings. They should. Abuse of alcohol and narcotics is a symptom, as is a psychotic depression. Abuse of addictive substances are brought on as a result of an inability to effectively cope with adjustments to the urban lifestyle or changes occurring in the rural or reservation environment. Available information is somewhat restrictive in scope, largely because the bulk of alcohol and drug research in general is conducted on urban residents. However slim the information, it still would be safe to conclude that substance abuse is

a response to a variety of identifiable stress-producing agents. The extent to which social mobility and environmental change affects substance abuse levels is open to question.

General Summary and Recommendations

Salient mental health and substance abuse findings concerning rural and migrant ethnic-minorities have been presented. Articles selected capture the major themes in the research literature. Where appropriate, emphasis is placed on identifying knowledge gaps.

Current understandings of ethnic-minority are derived from contemporary psychiatric and scientific orientations. Findings generated by these approaches cater to the needs of academicians, professionals, practitioners, and decision makers but miss the mark when reflected against ethnic folklore; very few studies have attempted to examine mental health and substance abuse from the native worldview.

Understanding, prediction and control are the major goals of science. From the review of work conducted on the major theme of this paper, it would indeed seem plausible to suggest that science has not come too far. For the most part, mental health and substance abuse is still largely at the understanding stage. There is not enough data to accurately predict how we will cope with change through migration. General categories of knowledge exist, however, they are insufficient for predicting behavior with absolute certainty.

There is another side to the issue. Research on rural and migrant ethnic minorities is presumptuous; many investigators assume that rural and

migrant folk have little understanding of the needs and problems. Moreover, many assume that folk do not have the knowledge and skills to prevent problems. Oddly enough, cultural groups have evolved prevention and treatment strategies for practically every known condition. Future understandings can gain immensely if efforts are focused on identifying indigenous mechanisms used to control and prevent emotional problems and abuses of narcotics and alcohol.

The presence of knowledge gaps commands attention. Some of the important areas in which work is needed are listed below without comment.

1. The physical and mental health of migrants compared to urban nonmigrants with appropriate controls for situational characteristics, migrant experiences, age, susceptibility to emotional disturbance, occupational backgrounds, etc.
2. Psychosocial characteristics of the effectively coping person who has managed to accommodate and adjust to new environments.
3. Comparisons of urban-born children of rural-urban migrants with urban-born children of urban nonmigrants and urban-urban migrants.
4. Identification of salient coping mechanisms that foster transcultural competence in adapting to varieties of mental health conditions.
5. Knowledge of the characteristics and motivations of returnees, nonreturnees to rural areas compared to initial migrants, nonreturnees, and rural nonmigrants.

6. Implementation of training programs aimed at utilizing the talents of local residents towards establishing prevention and control strategies.
7. Accelerated efforts at eliminating racial barriers that block attempts to successfully cope with new and changing environments.
8. Development of research paradigms that more accurately reflect cultural perspectives and lifestyles.
9. Longitudinal or cross-lagged cohort studies should be designed to monitor mobility experiences and psychiatric disturbance which would allow for within and between group comparisons.
10. Identification and implementation of prevention strategies that utilize known effective contemporary procedures in tandem with traditional cultural practices.

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